OLDHAM COUNTY BOARD OF EDUCATION
ADMINISTRATIVE REGULATION FORM

SEIZURE ACTION PLAN 9009.05F

Student Name: _____ DOB: _____

School: _____ Grade/Year: _____

Treating Physician: _____ Office Number: _____

Type/s of Seizure: _____ Date of Diagnosis: _____

SEIZURE INFORMATION:

DATE OF LAST KNOWN SEIZURE	SEIZURE TYPE	DESCRIPTION

Seizure triggers or warning signs:

_____

Student's likely characteristics during and reaction after seizure:

_____

EMERGENCY RESPONSE:

SEIZURE EMERGENCY PROTOCOL (*check all that apply*):

- ☐ Time seizure
- ☐ Contact School Nurse/office at: _____
- ☐ Administer emergency medication if indicated below
- ☐ Notify parent or emergency contact
- ☐ Other: _____

CALL 911 if:

- ✓ Emergency medication is administered *(911 is required if emergency med given)*
- ✓ Respiratory distress
- ✓ Student has repetitive seizures
- ☐ Other: _____

Basic Seizure First Aid:

- Stay calm and track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child
- Record seizure in log
- Protect head (for grand mal)
- Keep airway open
- Turn on side

A seizure is generally considered an **Emergency** when:

- A convulsive seizure is **longer than** 5 min
- Repeated seizures without regaining consciousness
- First time seizure
- Student injured or diabetic
- Breathing difficulties
- Seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS:

Will student require Emergency Medication at school? ☐ YES ☐ NO

Does student take daily seizure medication at home?

☐ YES ☐ NO If yes, please list: _____

Does student have a Vagus Nerve Stimulator?

☐ YES ☐ NO If yes, describe use of magnet: _____

OLDHAM COUNTY BOARD OF EDUCATION
ADMINISTRATIVE REGULATION FORM

SEIZURE ACTION PLAN 9009.05F

PRESCRIBED EMERGENCY MEDICATION FOR SCHOOL:

(Please select and complete directions for use)

☐ **DIASTAT** *Rectal Gel* For school staff: ☐ Green ready band visible and locked with correct dose

Dose: _____ MG PER RECTUM to be administered _____ minutes after onset of seizure

Other directions: _____

Expiration Date: _____

☐ **KLONOPIN** *Buccal Tab*

Dose: _____ MG to be administered between cheek and gum ____ minutes after onset of seizure.

Other directions: _____

Expiration Date: _____

☐ **NAYZILAM** *(Midazolam) Nasal Spray*

Dose: _____ MG single spray into one nostril _____minutes after onset of seizure.

Other directions: _____

Expiration Date: _____

☐ **VALTOCO** *(Diazepam) Nasal Spray*

Dose: _____ MG single spray into one nostril_____ minutes after onset of seizure.

Other directions: _____ Expires:_____

Expiration Date: _____

This medication can be kept: ☐ On Student ☐ Classroom ☐ Office/Health Room

This medication is required to be available on the bus: ☐ *YES * *See transportation directives on page 2* ☐ NO

TRANSPORTATION DIRECTIVES:

In the event of a seizure during transport, student will remain in seat with breathing and airway status monitored by bus staff. **If respiratory distress is noted, or seizure does not subside, 911 will be called.**

Is Emergency Medication to Be Administered on The School Bus Route to And from School?

☐ **YES*** ☐ **NO**

***If an emergency medication is prescribed by the physician to be administered during bus transportation to/from school, two trained staff members are required and available only on a "specially equipped" bus.*

Is Emergency Medication to Be Administered During Bus Transportation on Field Trip Events?

☐ **YES*** ☐ **NO**

For ***regular education students with a prescribed emergency medication:*
*Tansportation will be provided on a 'specially equipped' bus for field trip events unless parent **and** physician sign the **Waiver of Special Transportation on the following page:***

OLDHAM COUNTY BOARD OF EDUCATION
ADMINISTRATIVE REGULATION FORM

SEIZURE ACTION PLAN 9009.05F

PARENT LIABILITY WAIVER AND RELEASE OF INFORMATION

I understand that the employees of the Oldham County Board of Education to whom health services are delegated may not be licensed healthcare professionals. In the case of an emergency that requires immediate intervention at school or at a school event, employees who have been delegated health services will undertake to do their best to comply with the recommended protocols developed by the student's physician, in accordance with training conducted by a Registered Nurse. I hereby consent to the interventions of the employee in accordance with the instructions above/attached. Additionally, in accordance with KRS 156.502 and 158.383(4), I agree to hold staff members harmless for any injuries resulting from the emergency care, medication administration, or reaction to any medication administration unless the injury was caused by the Board of Education employee's negligence.

I further hereby give my consent for medical records and reports to be shared with the Oldham County Board of Education and for my child's physician, referenced above, to discuss my child's medical condition with designated District personnel to assist them in planning for my child's care while at school or at school events.

_____ _____

Parent/Guardian Signature *Date*

Phone: _____

_____ _____

Physician Signature: *Date:*

Phone: _____

WAIVER OF SPECIALLY-EQUIPPED TRANSPORTATION AND RELEASE OF LIABILITY

I hereby request waiver of special transportation for field trips during the current school year. I understand that my child is entitled to special transportation due to my child's medical condition and that special transportation has been offered by the district at no additional cost to me.

I understand that declining special transportation will result in my child being transported by regular school bus unless the students are travelling by charter bus. The space limitations and configuration of bus seats on a regular bus pose additional safety risks to my child and especially in the event that Diastat is the prescribed medication to be administered. I have evaluated the risks to my child and determined that it is in my child's best interest to be transported by regular bus.

To the extent allowable by law I, for myself, my spouse, my child and our heirs, hereby indemnify and hold harmless my child's school and Oldham County Board of Education, their members, officers, employees, agents, insurers, successors and assigns from any liability, damages, or injury sustained by my child as a result of the administration of Diastat or other Emergency Medication on a regular school bus while traveling to and from school field trips.

_____ _____

Parent/Guardian Signature *Date*

I have reviewed the child's medical condition and the risks associated with traveling on a regular school bus and I agree with the parent's request to waive specially-equipped transportation during school field trips.

_____ _____

Physician Signature: *Date:*

FOR OFFICE USE ONLY:

Medication brought in by: _____ Date: _____

Medication picked up by: _____ Date: _____

Reviewed by OCBE RN: _____ Date: _____